Policy: Medical Record Documentation and Amendment Guidelines

ORGANIZATIONAL: Effects two or more departments.							
Folder	Organizational Choices: Health Information Mgmt			**Sub-Folder** (If Applicable)	**n/a**		
Original Effective Date	4/1/2003	**Scope**	*What departments does this policy apply to? State "All" as is may apply to the entire organization.* *All*				
Approved (Approver/Date)	Director of HIM, 9/12/2018; Assistant Vice President of Nursing, 9/12/2018; MDRC 9/20/2018						
Last Reviewed/ Revised Date	9/12/2018	**OSHA Category** (If Applicable)	Not Applicable	**Standard** (If Applicable)	*RC 01.01.01* *RC 02.01.01* *IM 02.01.03*	**Number of pages**	5

PURPOSE: *Why does this policy exist?*

- To ensure proper documentation of health care services and items provided to patients of Southeast Health. Proper medical record documentation not only supports high quality patient care (e.g., treatment, continuity of care), but also assists in accurate and timely claims review and payment that may be used as a legal document to verify health care items and services provided. The health record provides the basis for planning patient care and continuity of that care, and its accuracy is critical to patient safety and the best outcomes.
- To provide guidance on instances in which an amendment and/or late entry is necessary to support the integrity of the health record.

SKILL LEVEL: *Who is qualified to perform this procedure?*
All individuals authorized to document in the electronic health record.

GUIDELINES: *What are some general statements regarding the use of the policy?*
A complete and legible medical record shall be maintained for each individual who is evaluated and/or receives clinical treatment.

<u>GENERAL DOCUMENTATION GUIDELINES</u>

- All entries shall be signed or initialed/authenticated by the provider.
- Record times based upon 24-hour military time.
- Document in a timely manner.
- Chart after the delivery of care, not before.
- Chart only care you provide or supervise.
- Use only hospital-approved abbreviations and symbols.

- No response documented indicates “Not assessed at this time” or not applicable.
- Choose descriptive words and phrases that convey exact meaning clearly and concisely.
- Documentation should reflect factual information: what is seen, heard, palpated, and what care is being provided for the patient and response to said care.
- Never erase or obliterate information with correction fluid or black markers.

Providers documenting within the electronic record must avoid indiscriminate use of amendments as a means of documentation. All attempts to correctly identify patients and their medical conditions should be made prior to documenting within the record.

PROCEDURE: *Include: Definitions , Equipment , Process, and Documentation*

DEFINITIONS

Addendum: An addendum is used to provide additional information that was not available at the time of the original entry. The addendum should be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed or initialed by the person making the addendum.

Amendment: An amendment is a means of clarifying or correcting health information to a dictated report or direct data entry after the final signature has been obtained. Amending can include:

- Making corrections to original documentation
- Deleting or retracting information that was originally documented

Late Entry: A late entry is a form of an addendum in that it supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information, and signs or initials the late entry.

Versioning: Refers to the storage and management of previous versions of a piece of information, documentation, or documents for security, diagnostics, and regulatory compliance. While the EHR has the ability to hide from view original entries once replaced with corrected entries, **the original information must be retained and made available as necessary**. This is accomplished through versioning. Versioned documents are not viewable by staff. These documents are available if needed by contacting IT or the HIM Department.

DOCUMENTATION GUIDELINES – NON-COMPUTERIZED

- Document in blue or black ink; no felt-tip pen.
- Every entry must be dated, timed, and signed.
- Write legibly.
- Two patient identifiers must be on every page (patient name, account number, date of birth, etc.) (front and back if two-sided).
- FLOWSHEETS:
    - Place an "X" in the boxes that apply or circle the appropriate responses.
    - If a subject on the flowsheet requires a written response, and the response is not applicable, write "NA" in the corresponding space.
- NARRATIVE NOTES:
    - Each page (front and back if two-sided) must be dated.
    - Each page (front and back if two-sided) of notes must have the first initial, full last name, and credentials of individual documenting on the sheet.
- BLOCK CHARTING:
    - Documentation may be recorded with entries flowing consecutively.
    - All entries must be timed and initialed. All entries on patient care and activities flowsheets should be timed and initialed due to various staff documenting on the same sheet.

PROCEDURE FOR AMENDMENTS TO HAND-WRITTEN MEDICAL RECORD DOCUMENTATION

A. PROCEDURE FOR CORRECTING HAND-WRITTEN ENTRIES IN THE MEDICAL RECORD:

1. Draw a single line through the incorrect information so that it is still legible.
2. Write the word "ERROR" above or beside the original entry.
3. Place the date and your initials next to the word "ERROR."
4. Enter the correct information.

B. PROCEDURE FOR MAKING A LATE ENTRY TO HAND-WRITTEN MEDICAL RECORD DOCUMENTATION:

When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record:

1. Identify the new entry as a "late entry."
2. Enter the current date and time; do not try to give the appearance that the entry was made on a previous date or an earlier time.
3. Identify or refer to the date and incident for which the late entry is written.
4. If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get the information to write the late entry, i.e., use of supporting documentation on other facility worksheets or forms).
5. When using late entries, document as soon as possible. There is not a time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes.

PROCEDURE FOR AMENDMENTS TO ELECTRONIC HEALTH RECORD DOCUMENTATION

A. PROCEDURE FOR AMENDING/CORRECTING/MODIFYING DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD:

If documentation is found to be incomplete or inaccurate, the provider who generated the documentation will be responsible for creating an addendum or amendment to the report. The addendum or amendment will detail information that needs to be added to or revised in the original documentation. The correction must be made in the source system (where the document was originally created) when possible and then will be versioned in the EHR.

B. PROCEDURE FOR DOCUMENTING A LATE ENTRY ELECTRONICALLY:

It is strongly recommended that documentation only be entered into the electronic health record for up to 72 hours following the patient's discharge; however, all nursing documentation MUST BE completed within 30 days of discharge.

C. UNCHARTING IN THE ELECTRONIC HEALTH RECORD:

Errors involving documentation placed on the wrong patient's chart may be corrected in the electronic health record through the "unchart" process. Unchart is used if you enter information in error, for example, on the wrong patient's chart or in the wrong cell. A reason for uncharting is required.

In the event that modification or a late entry to the original documentation is made after the original documentation has been distributed to primary care providers or referring providers, the HIM Department must be contacted or alerted to send the revised documentation.

Refer to the User Guide appropriate to the computer application being used for step-by-step instructions on charting, amending, correcting, modifying, and uncharting in the EHR.

Falsified Documentation: Clinicians are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of purposely inaccurate entries or documentation
- Back-dating entries
- Pre-dating entries (creating documentation for care prior to performance of services)
- Modifying documentation in the electronic health record that does not comply with the methods outlined in this policy or are in direct contrast to regulatory body requirements.

Corrections, late entries, deletions, amendments, and addenda to medical records entered prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record

following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Medicare.

Appeal of claims denied on the basis of an incomplete record may result in a reversal of an original denial if the information supplied includes pages or components that were not part of the original medical record submitted for initial review, but are found to be a true and accurate reflection of care and services provided to the patient.

REFERENCES: *What resources are used to support the policy and procedure?*

LaTour, K. M., Eichenwald Maki, S., & Oachs, P. K. (2013). *Health information management: Concepts, principles, and practice* (4th ed.). AHIMA Press: Chicago, IL.

Joint Commission. (2017, January). E-dition Joint Commission. Retrieved September 27, 2017, from www.editionjcrin.com.

RELATED POLICIES AND PROCEDURES:

Abbreviations
Authorization to Document in the Medical Record

Attachments: (Label as Appendix A, B, C, etc.)